KERATAN AKHBAR 1/07/2026 (Rabu)

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New base medical insurance plan to begin by month's end

KUALA LUMPUR: The new base medical and health insurance/takaful (MHIT) plan will enter its pilot phase by the end of this month as authorities step up efforts to tackle rising medical costs.

Finance Minister II Datuk Seri Amir Hamzah Azizan said the pilot programme, involving selected insurers, takaful operators and private hospitals in the Klang Valley, forms part of the government's RESET strategy introduced in June last year to address rising healthcare costs and private medical insurance premiums.

He said the base MHIT plan is expected to be rolled out nationwide in January 2027.

"The government introduced the RESET strategy as a comprehensive, targeted and high-impact framework to control rising healthcare costs and private medical insurance premiums," he said during the Minister's Question Time at the Dewan Rakyat yesterday.

> **"This creates a transparent framework and benchmark to manage hospital charges while protecting consumers' interests."**
>
> Datuk Seri Amir Hamzah Azizan

Amir Hamzah said the strategy is overseen by the Joint Ministerial Committee on Private Healthcare Costs, comprising the Finance Ministry, Health Ministry, Bank Negara and other stakeholders.

He said the committee has made "significant progress" since its establishment, with five key initiatives already implemented.

These include the publication of the white paper on MHIT in January 2026, the release of common treatment cost ranges at private hospitals to improve price transparency, the World Bank's medical inflation report in April, consumer tools to help Malaysians assess insurance needs and claims and tax incentives for charitable funds set up by private hospitals.

He added that the Basic MHIT plan will be reinforced by the phased implementation of the Diagnosis-Related Group (DRG) payment system, which aims to standardise hospital charges and allow fairer, centralised negotiations with private hospitals.

"This creates a transparent framework and benchmark to manage hospital charges while protecting consumers' interests," Amir Hamzah said.

Responding to concerns from Simpang Renggam MP Datuk Seri Hasni Mohammad over reduced government spending, Amir Hamzah said the recent expenditure rationalisation would not affect core healthcare services.

He said the Finance Ministry had reduced the Health Ministry's operating expenditure adjustment to RM500mil, far below the RM3.1bil figure circulating on social media.

"The adjustment only involves non-critical operating expenditure. Core spending on healthcare services, medicines, salaries and on-call allowances remains unchanged."

He added that the allocation for medicines has been increased to RM6.5bil this year, while more than 18,000 healthcare workers will continue to be recruited without any reduction.

Amir Hamzah also revealed that several private hospitals have already established charitable funds for B40 patients following the introduction of tax incentives announced last year.

'Medicine imports stable'

Measures in place to prevent supply chain disruptions

By QISTINA SALLEHUDDIN, RAHIMY RAHIM and KHOO JIAN TENG
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KUALA LUMPUR: Malaysia is taking steps to safeguard the supply of imported medicines against potential disruptions from the Middle East conflict by diversifying its sources of supply and manufacturers.

Health Minister Datuk Seri Dr Dzulkefly Ahmad (*pic*) said this includes securing alternative suppliers and source countries to reduce reliance on a single source.

He said other measures were maintaining buffer stocks and implementing long-term procurement contracts to strengthen supply chain resilience.

"Our supply of imported medicines remains stable including in Sabah, despite the state's geographical and logistical challenges.

"Among the measures implemented to ensure a continuous supply of medicines are regular monitoring of supplies by Product Registration Holders (PRHs) and inventory checks at healthcare facilities and concession companies to detect potential shortages at an early stage.

"We are also centralising procurement and implementing long-term contracts to improve supply stability and reduce the risk of supply chain disruptions," he said in a parliamentary written reply on Monday.

Dzulkefly said the ministry, through the National Pharmaceutical Regulatory Agency, also monitors medicine supplies under the Medicine Supply Disruption and Discontinuation Reporting system.

He also said PRHs are required to notify the agency of any anticipated medicine supply disruptions up to six months before a shortage is expected to occur.

"However, if a disruption arises unexpectedly, PRHs must report the matter immediately.

"The reporting requirement was implemented on a voluntary basis since Aug 1 last year. Mandatory reporting takes effect from July 1."

Dzulkefly said the ministry is strengthening inventory planning and stock assurance at healthcare facilities to ensure sufficient supplies, particularly in rural and hard-to-reach areas in Sabah.

"We are also enhancing the functions of the Sabah state pharmaceutical logistics hub and the medicine distribution network to improve the efficiency of storage and the delivery of supplies to hospitals and health clinics throughout the state," he said.

NST M/S 13, 16

Dangerous heat stress has surged

THE number of people exposed to dangerous heat stress worldwide has risen sharply over the last half century, propelled by climate change, according to a study.

Heat stress, the name given to the hazardous build-up of body heat caused by soaring temperatures, humidity and other factors, is one of the most common ways that extreme weather kills people.

The new study, published in the journal 'Nature Climate Change', tracked how heat stress levels have surged between the 1970s and 2024.

"On every continent, strong to extreme heat stress is now more frequent," lead study author Rebecca Emerton, of the European Centre for Medium-Range Weather Forecasts, told AFP.

In the 1970s, for example, 16 per cent of the world's population experienced at least one day of extreme heat stress — when the "feels-like" temperature was at least 46°C. Fifty years later, the rate has risen to 22 per cent.

"That might not sound like so much, but that's an extra approximately one billion people who are seeing at least some extreme heat stress now that wouldn't have been experienced in the 1970s," Emerton said.

The study used the Universal Thermal Climate Index (UTCI), which represents the temperature it "feels like", by including factors such as humidity, wind, radiation and how the human body responds to heat.

The daily average UTCI has been rising as heat stress events become more frequent, severe and longer-lasting due to human-driven global warming, the research found.

Some countries, including Spain, Portugal, Italy and France, are now experiencing "feels-like" temperatures up to five degrees hotter than they did in the 1970s, Emerton said.

Heat stress is also "expanding into areas of the globe where historically it's not been experienced," Emerton added.

For example, very strong heat stress with a "feels-like" temperature of at least 38°C has now reached parts of North America, the United Kingdom and Scandinavia, she said.

The researchers also tracked the global rise of unrelentingly hot nights.

During nights when "you can't get any relief, and your body can't cool down, that becomes very dangerous for people's health, particularly for vulnerable people", Emerton said.

Most of the world has seen increases in the number of tropical nights, when the "feels-like" temperature does not get below 20°C, the researchers found.

The study only looked at data up to 2024. However, Emerton said the heatwaves already pummelling Europe this year suggest the trend has been continuing.

MEDICAL INFLATION A REAL HEADACHE

Problem with looking only at bill is it treats final number as though it explains itself

DR KAMAL AMZAN

EVERY now and then, I ask myself a simple question. If private hospitals were to provide rooms for free, would medical inflation fall?

If medicines were charged at retail pharmacy prices, ignoring for a moment that hospital overheads would put most retail operations to shame, would medical inflation fall?

If we absorbed more costs into room rates, bundled more services, stopped itemising certain consumables, and charged "reasonably", would the public finally say, "Yes, that is fair"?

Or would the answer be: "Thank you, but please discount the rest as well"?

This is not a rhetorical exercise in irritation, although I confess there are days when it comes close. It is a serious question about how Malaysia understands the cost of care.

A hospital bill is not a supermarket receipt. Behind every line item sits a chain of people, systems and risks: nurses, pharmacists, radiographers, infection control teams, biomedical engineers, clinical waste management, sterilisation, utilities, maintenance, emergency readiness, regulatory compliance, technology upgrades, drugs that must be available before they are needed, and staff who must be present even when no one notices them.

Yet in the current debate, it has become tempting to reduce medical inflation to one convenient villain: private hospital prices. It is neat. It is emotionally satisfying. It is also wrong, or at least far too incomplete to be useful.

THE PRICE IS VISIBLE, THE SYSTEM IS NOT

The Public Accounts Committee report has raised concerns about private hospital charges, non-professional fees, mark-ups, unbundling and differences between cash-paying and insured patients. These issues deserve to be examined seriously.

Any industry that touches patients' lives must be prepared for scrutiny. Private hospitals should not be above questioning. We must justify our charges, explain our cost structures, improve transparency and remove practices that cannot be defended.

But scrutiny is not the same as simplification.

The problem with looking only at the bill is that it treats the final number as though it explains itself. It does not. A bill tells us what was charged. It does not, by itself, tell us what was necessary, what was subsidised, what was underpriced, what was bundled, what was inefficient or what was clinically unavoidable.

If hospitals are told that medicines cannot carry a margin, consumables cannot be itemised, room rates must remain low, intensive care unit charges must remain modest, nursing charges must not rise, operating theatre usage must be constrained, and doctors' fees must remain tied to schedules that have not kept pace with reality, then we should at least be honest about the question being asked.

We are not asking for transparency. We are asking private hospitals to provide increasingly complex care while pretending that complexity does not cost money.

MEDICAL INFLATION IS NOT HOSPITAL PRICE INFLATION

One of the most important clarifications in this debate is also one of the least discussed.

The 14 per cent to 16 per cent medical inflation figures often quoted in Malaysia are not simply a measure of private hospital price increases. They reflect broader medical cost trends.

Claims rise because of many factors: the number of people seeking care, the severity of illness, the complexity of treatment, new technology, newer drugs, ageing, chronic disease, benefit design, patient behaviour, provider behaviour and the commercial promises made by insurers.

If more Malaysians are developing diabetes, hypertension, cancer, kidney disease and heart disease, claims will rise. If insurance products promise cashless access with little friction at the point of care, utilisation will rise.

A hospital bill is not a supermarket receipt as behind every line item sits a chain of systems, risks and people, such as nurses. NSTP FILE PIC

If policyholders who have paid premiums for years finally seek care when they are unwell, claims will rise.

And if premiums go up even for people who have not made claims, that is not a hospital pricing issue alone. That is an insurance pooling, pricing, product design and claims management issue.

The uncomfortable truth is this: a healthcare bill is not created only in the hospital. It is created over years, through population health, product design, underwriting assumptions, lifestyle risk, delayed prevention, utilisation behaviour and clinical need. By the time the patient reaches the ward, the bill has already begun.

PERHAPS WE COULD START BY READING THE REPORTS

One wishes the national conversation had begun with the reports, rather than the headlines. This may sound unfashionable, but reports do have their uses. Some of them even contain evidence.

The World Bank and other health system analyses have pointed repeatedly to Malaysia's wider pressures: ageing, non-communicable diseases, fragmented care, underinvestment in prevention, rising expectations and the need to shift from paying for treatment to paying for value.

These are not obscure issues. They are not hidden in footnotes written in invisible ink. They are the large, structural drivers of healthcare cost.

Yet somehow, after years of warnings that Malaysians are getting older, sicker and more expensive to treat, the public conclusion now appears to be that private hospitals have simply been charging too much. That is a wonderfully convenient diagnosis. Convenient, but incomplete.

It is also worth asking how this impression was formed. Based on recent reporting, some of the strongest claims came from insurance industry leaders themselves, including allegations about overutilisation, medical equipment, hospital pricing practices and the supposed commercial behaviour of private hospitals.

Their statements deserve to be heard. But they also deserve to be interrogated, because insurers and payers are not neutral observers of patient behaviour. They are active designers of it.

For years, insurance products have been built around the promise of cashless access, wide coverage, convenience and reassurance. These products shape expectations. They influence when patients seek care, what patients believe they are entitled to, and how patients behave at the point of treatment.

This is not an accusation. It is product design. If you engineer a product that tells patients "You are covered, seek care when needed, do not worry about payment at the point of care", then it should surprise no one when patients behave as though they are covered, seek care when needed and do not worry about payment at the point of care.

To then treat rising utilisation as though it is mainly the moral failure of hospitals is rather elegant, in the way only selective memory can be elegant.

Hospitals do not design insurance benefits, price premiums, determine pooling assumptions, or decide how much friction, co-payment or gatekeeping a policy should contain. Hospitals do not sell the promise of cashless care and then rediscover prudence only when claims are submitted.

So yes, let us examine hospital charges. But let us also examine the products that shaped demand, the promises that shaped behaviour, the pricing that underestimated risk and the national health profile that made higher claims almost inevitable. A serious country cannot read only the invoice and ignore the epidemiology. And a serious reform conversation cannot begin with the conclusion already chosen.

PRIVATE HEALTHCARE MUST REFORM, BUT SO MUST THE SYSTEM

We should improve billing clarity, reduce unjustified variation, and work with regulators, insurers and clinicians on value based care. We should examine where outcomes can be maintained while costs are reduced. We should be prepared to move from volume to value.

This is not theoretical. We have been working on value-driven outcomes, clinical pathways, procurement discipline, generics where clinically appropriate, digitalisation and better cost visibility. We accept that the private sector must be part of the solution.

But being part of the solution is not the same as accepting a distorted diagnosis. The danger of blaming private hospital prices as the main reason for medical inflation is that it gives the country the comfort of a simple answer. Simple answers are politically useful. They are rarely clinically useful.

Medical inflation is a system problem. It sits at the intersection of national health, insurance design, clinical behaviour, patient behaviour, technology, regulation, labour costs, litigation risk and public expectations.

The tragedy of the current debate is that it risks mistaking the most visible part of the system for the most responsible part of the system. The hospital bill is visible. The insurance product is less visible. The actuarial assumptions are less visible. The neglected diabetes, hypertension and obesity are less visible.

But invisibility is not innocence. If we are serious about medical inflation, then everyone who helped design the system must sit at the table, not merely those whose invoices are easiest to photocopy.

The writer is chief executive officer of IHH Healthcare Malaysia

Sinar Harian M/S 19, 20

Doktor udara terima sumbangan peralatan perubatan

IPOH - Perkhidmatan Doktor Udara (FDS) menerima sumbangan peralatan perubatan bernilai RM124,000 bagi memperkukuh penyampaian perkhidmatan kesihatan kepada komuniti luar bandar di negara ini.

JAMES

Sumbangan tersebut disalurkan oleh Kedutaan Amerika Syarikat di Kuala Lumpur melalui program *Overseas Humanitarian, Disaster and Civic Aid* (OHDACA) di bawah Jabatan Pertahanan Amerika Syarikat (AS).

Ketua Pasukan Civil Military Support Element (CMSE) Malaysia, Kapten James Adam berkata, bantuan itu merupakan yang pertama daripada tiga sumbangan yang dirancang tahun ini, dengan dua lagi akan disalurkan ke Sabah dan Sarawak menjelang akhir Julai.

Menurutnya, pemilihan FDS dibuat kerana perkhidmatan itu memainkan peranan penting dalam menyediakan akses rawatan kesihatan kepada masyarakat yang sukar mendapatkan kemudahan perubatan.

"Kami yakin peralatan ini akan dimanfaatkan sepenuhnya oleh FDS dalam menyokong perkhidmatan kesihatan kepada komuniti yang memerlukan, khususnya di kawasan pedalaman," katanya ketika ditemui pemberita sempena majlis penyerahan peralatan tersebut di sini pada Selasa.

Sumbangan diserahkan kepada Kementerian Kesihatan Malaysia (KKM) yang diwakili Ketua Cawangan Pembangunan Kesihatan Awam, Jabatan Kesihatan Negeri Perak, Dr MA Muthu Chelvan.

Hadir sama, Pakar perubatan CMSE Malaysia, Jon Anderson serta Pengurus Besar Kumpulan Layang-layang Group, Kapten Shahdon Poong.

Peralatan yang disumbangkan termasuk mesin ultrabunyi, kit perubatan, stesen jana kuasa serta pelbagai peralatan diagnostik lain yang mampu meningkatkan keupayaan pasukan FDS memberikan rawatan lebih berkesan.

James berkata, sumbangan itu juga merupakan sebahagian daripada inisiatif sempena sambutan ulang tahun ke-250 kemerdekaan Amerika Syarikat.

"Walaupun nilai sumbangan ini sekitar AS$30,000, kami percaya manfaatnya akan berganda melalui rawatan kritikal yang dapat diberikan kepada pesakit," katanya.

Portal rasmi KKM ditutup sementara

PUTRAJAYA – Kementerian Kesihatan Malaysia (KKM) memaklumkan capaian ke Portal Rasmi kementerian itu dihentikan sementara bagi membolehkan pengukuhan kawalan keselamatan siber dilaksanakan.

KKM memaklumkan pihaknya sedang menjalankan siasatan serta tindakan pemulihan bersama agensi berkaitan dan perkembangan lanjut akan dimaklumkan dari semasa ke semasa.

"Setakat ini, tiada petunjuk bahawa insiden berkenaan menjejaskan sistem kritikal atau mengakibatkan kebocoran data kritikal KKM.

"Sistem penyampaian perkhidmatan kesihatan KKM terus beroperasi seperti biasa dan dilindungi melalui infrastruktur berasingan dengan kawalan keselamatan siber yang ketat," menurut kenyataan KKM pada Selasa.

KKM turut memaklumkan portal berkenaan hanya digunakan bagi penyampaian maklumat korporat dan maklumat awam serta tidak menyimpan rekod perubatan pesakit atau data kesihatan individu.

Sabtu lalu, media melaporkan portal rasmi KKM mengalami gangguan capaian yang dipercayai berpunca daripada insiden keselamatan siber. - *Bernama*

Berita Harian M/S 15, 19

Penyelarasan bajet KKM tak jejas MHIT, strategi RESET

Cadangan hanya babit pengeluaran tak kritikal, bukan perbelanjaan teras kementerian

Laporan Muhammad Yusri Muzamir dan Mukhriz Mat Husin
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Kuala Lumpur: Kementerian Kewangan (MOF) memberi jaminan syor penyelarasan perbelanjaan mengurus Kementerian Kesihatan (KKM) tidak menjejaskan pelaksanaan Pelan Insurans/Takaful Perubatan dan Kesihatan (MHIT) dan strategi RESET.

Menteri Kewangan II, Datuk Seri Amir Hamzah Azizan, berkata ini kerana cadangan itu hanya membabitkan pengeluaran tidak kritikal, bukannya perbelanjaan teras KKM seperti diluluskan dalam Belanjawan 2026.

Beliau berkata, MOF juga sudah mempertimbangkan penyelarasan sejumlah RM500 juta bagi perbelanjaan mengurus KKM, berbanding cadangan asal bernilai RM3.1 bilion.

Langkah itu, katanya, bertujuan mewujudkan ruang fiskal bagi menampung sebahagian lonjakan perbelanjaan subsidi susulan krisis di Asia Barat.

"Jumlah ini tidak membabitkan perbelanjaan utama seperti emolumen, bekalan ubat, elaun lebih masa termasuk *on-call* dan sebagainya. Peruntukan ubat-ubatan juga terus dinaikkan kepada RM6.5 bilion tahun ini, berbanding RM6 bilion pada 2025.

"KKM tahun ini turut menyasarkan pengambilan lebih 18,000 petugas kesihatan tanpa sebarang pengurangan berbanding tahun sebelumnya.

"Ini membuktikan langkah penjimatan tidak menjejaskan keutamaan kerajaan memastikan rakyat terus menerima perkhidmatan kesihatan berkualiti," katanya pada sesi soal jawab lisan di Dewan Rakyat, semalam.

Beliau menjawab soalan tambahan Datuk Seri Hasni Mohammad (BN-Simpang Renggam) mengenai keputusan Jawatankuasa

Bersama menjayakan strategi RESET dan Pelan MHIT berikutan peruntukan KKM dipotong.

Lima teras strategik

RESET merujuk kepada lima teras strategik iaitu menambah baik tawaran MHIT; meningkatkan ketelusan harga; memperkukuh sistem kesihatan digital; memperluas pilihan rawatan yang berkesan dari segi kos dan mengubah mekanisme pembayaran penyedia perkhidmatan.

Amir Hamzah berkata, keadaan fiskal itu menjadikan agenda RESET semakin penting dan relevan, selain matlamatnya adalah untuk memastikan kos penjagaan kesihatan kekal mapan bagi jangka panjang.

"Inisiatif seperti pembayaran berasaskan Kumpulan Berkaitan Diagnosis (DRG) dan Rekod Perubatan Elektronik (EMR) bukan hanya menangani inflasi perubatan.

"Ia juga mengurangkan pembaziran, antaranya dengan mengelakkan ujian diagnostik berulang dan memastikan bayaran rawatan lebih telus serta berasaskan nilai," katanya.

Beliau berkata, pendekatan kecekapan itu selari usaha kerajaan melalui penguatkuasaan Akta Perolehan Kerajaan 2026 bagi membantu mencegah ketirisan, pemborosan dan pembaziran dana awam yang dijangka bermula 2027.

UPM terajui inovasi air rawatan dialisis untuk pertanian

Kuala Lumpur: Universiti Putra Malaysia (UPM) mengambil inisiatif mengitar semula 1.3 juta liter air setahun yang digunakan bagi dialisis pesakit buah pinggang di Hospital Sultan Abdul Aziz Shah (HSAAS) yang kemudian dibuang ke longkang, untuk projek lebih bermanfaat bagi mengelak pembaziran.

Projek itu dilaksanakan UPM yang kini menerajui inovasi hijau DROP to CROP, iaitu inisiatif memanfaatkan air buangan proses osmosis songsang (RO) daripada rawatan dialisis untuk kegunaan pertanian dan akuakultur.

Pakar Perunding Buah Pinggang Hospital Sultan Abdul Aziz Shah (HSAAS) UPM, Dr Wan Zul Haikal Hafiz Wan Zukiman, berkata pelaksanaan projek itu tercetus ekoran pemerhatian terhadap jumlah air mentah yang sangat besar dibuang begitu saja ketika proses penyediaan air suling untuk rawatan pesakit buah pinggang.

Beliau berkata, air digunakan bukan air tercemar hasil proses dialisis pesakit, sebaliknya air sisa RO yang tidak digunakan ketika merawat pesakit.

"Bagi satu sesi rawatan empat jam, seorang pesakit akan menggunakan antara 150 hingga 200 liter air RO dan bagi penghasilan 200 liter air RO, ia memerlukan 400 liter air mentah.

"Jadi sebanyak 200 liter air lagi dibuang ke longkang, sekali gus menjadikan jumlah air yang dibazirkan sangat besar.

"Jika pusat dialisis mempunyai 20 pesakit sehari, dianggarkan hampir 4,000 liter air dibuang begitu saja ke longkang dalam tempoh sehari," katanya ketika ditemui di Pusat Intervensi Buah Pinggang dan Dialisis Putra (PRINCE) di HSAAS UPM, di sini, semalam.

Pelancaran projek itu diadakan pada 7 Julai lalu di PRINCE sempena Hari Bersama Pesakit Dialisis dan Program Diet Pesakit Dialisis.


Dr Wan Zul Haikal Hafiz menunjukkan air sisa RO untuk penggunaan pengairan tanaman dan akuakultur di kampus UPM. (Foto Aziah Azmee/BH)

Naib Canselor UPM, Datuk Prof Ir Dr Ahmad Farhan Mohd Sadullah dan Pengerusi Lembaga Pengarah Universiti UPM, Datuk Seri Jailani Johari melepaskan ikan tilapia ke dalam tong air sisa RO dialisis, sebagai simbolik penggunaan air berkenaan bagi projek akuakultur.

Dr Wan Zul Haikal Hafiz berkata, di HSAAS UPM, unit hemodialisis kini merawat 43 pesakit dengan setiap pesakit menjalani tiga sesi rawatan seminggu.

Susulan itu, beliau berkata, jumlah air sisa yang dialirkan ke longkang mencecah lebih 1,248,000 liter setahun hanya untuk sebuah unit dialisis yang bersamaan kira-kira dua pertiga isi padu sebuah kolam renang bersaiz olimpik.

Sementara itu, Dr Wan Zul Haikal Hafiz percaya mungkin ada pihak yang meragui penggunaan air ini kepada sumber makanan.

Beliau berkata, hasil kajian dilakukan mendapati sayuran menggunakan air ini tumbuh segar dan saiznya lebih besar berbanding tumbuhan lain.

"Antara tumbuhan ditanam adalah bayam dan kangkung yang tumbuh dengan baik. Jadi, projek ini perlu diteruskan untuk mencapai hasrat kelestarian ditetapkan kerajaan, Matlamat Pembangunan Mampan (SDG) dan Pertubuhan Kesihatan Sedunia (WHO)," katanya.